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ABSTRACT

To develop skills and understanding of interdisciplinary teamwork, the University of Miami's Department of Family Medicine and the School of Nursing conducted a project involving 10 teams of medical, nursing, and social work students. The primary objectives of the project were: (1) to instill and maintain positive attitudes in student physicians, nurses, and social workers toward interdisciplinary teamwork in the delivery of comprehensive health care, and (2) to increase mutual understanding of the differing orientations and skills of these professions. Based on data collected by such means as closed-circuit television and objective testing, significant differences between experimental and control groups were not revealed. However, the comparison group showed some significantly less favorable attitudes toward certain concepts. Subjective evaluations from students, preceptors, and families indicated project success. The study points to the need for more opportunities for student teams to work together early in their professional education and has implications for curricular modifications in health professional schools. Evaluation forms are appended. (JS)

Project O-D-067

Final Report

Project No. O-D-067
Grant No. OEG-4-71-0020

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AN INTERDISCIPLINARY EDUCATIONAL PROJECT IN COMPREHENSIVE FAMILY HEALTH CARE

February 28, 1972

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Office of Education

National Center for Educational Research and Development
(Regional Research Program)

ABSTRACT

The University of Miami's Department of Family Medicine and the School of Nursing demonstrated a one year (1970-71) pilot health team educational project. The primary objectives were to instill and maintain positive attitudes in students toward interdisciplinary teamwork and comprehensive health care, and to increase understanding of the different orientations and skills of these health professions. Ten student teams, each composed of one medical, nursing and social work student, supervised by faculty preceptors from the three disciplines, provided comprehensive health care for one family per team.

The program content for experimental student teams emphasized delivery of total health care through implementation of a family health care plan. Preceptors supervised through closed-circuit television and one-way mirror, and by regular team conferences and seminars.

Significant differences between experimental and control groups were not revealed through objective testing, although the comparison group (non-choosers) showed some significantly less favorable attitudes toward certain concepts. Subjective data, evaluations from students, preceptors, and families, indicated project success. This study points to the need for more opportunities for student teams to work together early in their professional education and has implications for curricular modifications in health professional schools.

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Implementation of the student health team concept is an innovation in current health education despite numerous suggestions in the literature[1-6] that students should learn and work together if they are to participate later in effective interprofessional teamwork. Leading educators[7-8] advocate reaching students early in their professional education to affect attitudes and behaviors positively, and to avoid stereotyping and role rigidities. To develop skills and understanding of interdisciplinary teamwork, the University of Miami's Department of Family Medicine and the School of Nursing demonstrated a one year pilot project. Ten student health teams, each composed of one medical, nursing and social work student, supervised by a faculty preceptor team from the three disciplines, provided comprehensive health care for one family per team (October through May, 1970-71).

The primary objectives of the project were: 1) to instill and maintain positive attitudes in student physicians, nurses and social workers toward interdisciplinary teamwork in the delivery of comprehensive health care; and 2) to increase mutual understanding of the differing orientations and skills of these professions.

METHOD

Selection of Students: Forty-five of the first year class of medical students (115) volunteered for the project. Of these 45 choosers, 10 were randomly assigned to the experimental group for the project, and 12 were assigned to the control group. A comparison group of 14 students was randomly selected from the 70 non-choosers in the class. Control and comparison groups participated only in pre and post-project attitude testing.

Experimental (10), control (10), and comparison (9) nursing students were chosen in the same manner from the introductory nursing course. Since only two first year graduate social work students were available for the project, it was necessary to assign them to five teams each and no comparisons were possible.

Setting: A model family practice unit, within the medical center, was utilized. Family medicine has operated this unit since 1965, combining undergraduate and graduate teaching with delivery of comprehensive family health care to a broad, socioeconomic spectrum of private, fee-paying families. The Center is modern, well equipped and staffed to deliver care to approximately 1,000 families. Closed circuit television and one-way mirror facilitated student observation and teaching without inhibiting the patient or constricting student initiative.

Program Content: Ten families were chosen who were new to the Center and willing to work with students in an evening clinic. Visits with families over the seven month period ranged from five to 12 per team. The initial visit for every team was a family orientation meeting in which the three students interviewed the total family in order to learn about their social, medical and family history. A family health care plan was then designed with short and long term goals in each problem area identified by the students or family. This plan guided succeeding health maintenance visits and was modified to meet the family's developing needs.

Teams conferred with faculty preceptors (physician, nurse, social worker) before and after each subsequent visit to discuss the family's problems and needs, and the implementation of the health plan. Student's feelings and perceptions about family interactions, as well as about other team members and their roles were also discussed. In addition, a monthly student-directed seminar was held with students and preceptors on concepts of health team, comprehensive health care and family medicine, and other topics of student interest.

Objective Evaluation: Objective measures were related to attitude change. Experimental, control and comparison groups were measured at the beginning and end of the project on the Medical Attitudes Scale, used in the Hammond and Kern Colorado study[9] (36 items), Form E of the Rokeach Dogmatism Scale[10] (40 items), and on 10 concepts using Osgood's Semantic Differential[11]. Concepts relevant to the aims of the project were chosen. The same 15 bipolar adjectives were used to evaluate each concept.

Data Analysis: Data were analyzed by multivariate analysis of variance, testing the amount of change pre to post, on all scales, between experimental and control groups. In addition, experimentals and controls were compared with the non-chooser comparison group. Attitudes of nursing and medical students were compared at the end of the program to see how they differed, and separate evaluations for the medical and nursing groups showed amount of change pre to post for each group.

Subjective Evaluation: Subjective data included evaluations from students, preceptors, and families. At the conclusion of the project, a psychologist (outside rater) interviewed students individually for their final evaluation of the project. Preceptors evaluated each student on a rating scale and reported informal impressions. The families related their reactions concerning their health care and roles of the students on their health team.

RESULTS

Pre and post data were available on 61 medical and nursing students.

Objective Evaluation: In general, there were few differences between experimental and control groups. Using a total score on the Medical attitudes test, Dogmatism Scale, and factor scores on the 10 Semantic Differentials, the groups were not significantly different statistically ($P<.13$).

When the experimental, control, and comparison groups were evaluated, they were found to be significantly different in their concepts of (Semantic Differential) PSYCHOSOMATIC MEDICINE, NURSE, INDIGENT FAMILY, FAMILY MEDICINE and SOCIAL WORKER. Differences were all in the direction of being more positive for those who chose the family medicine elective (experimentals and controls). Groups did not differ on overall Medical Attitudes, Dogmatism, or concepts of PATIENT, DOCTOR, SOCIALIZED MEDICINE, or HEALTH TEAM; however, trends were again toward the choosers consistently having more positive attitudes.

Comparisons of medical and nursing students from the experimental group revealed their post attitude scores significantly different at $P<.001$. Table 1 shows 12 selected variables. As can be seen there were no differ-

ences in terms of Medical Attitudes and Dogmatism, although nurses tended to be slightly more dogmatic. Scores used from the Semantic Differential are the evaluative factor scores which Osgood has stated indicate attitude. At the 1% level of significance, the concepts of NURSE and SOCIAL WORKER were seen more favorably by nursing than by medical students. As the project focused on interdisciplinary teams, how each student viewed other team members was important. It is interesting that nurses held more positive views of both NURSE and DOCTOR, than medical students held of themselves and nurses. The nurse rated team members as NURSE 59.6, SOCIAL WORKER 58.1, and DOCTOR 57.3 while medical students rated the team, DOCTOR 56.5, NURSE 51.2. and SOCIAL WORKER 51.1.

TABLE I
Comparison Between Medical and Nursing Students
On Twelve Selected Variables

VARIABLES	MEDICAL STUDENT		NURSE		t-TEST
	Mean	S.D.	Mean	S.D.	
Medical Attitude	108.60	6.57	109.13	4.12	0.20
Dogmatism	116.10	17.46	120.75	23.31	0.48
Evaluative Factors (S.D.)					
Hospital	50.10	7.85	58.25	4.97	2.55**
Psychomatic Medicine	52.30	8.97	56.50	5.98	1.13
Nurse	51.20	6.05	59.63	3.16	3.55**
Indigent Family	43.10	9.86	41.50	8.65	0.36
Family Medicine	57.80	4.24	58.38	6.55	0.23
Patient	48.80	7.63	45.13	2.70	1.29
Social Worker	51.10	6.24	58.13	4.29	2.70**
Doctor	56.50	4.64	57.25	4.37	0.35
Health Team	55.40	5.93	57.13	6.29	0.60
Socialized Medicine	38.50	13.35	55.13	7.20	3.16**

**P <.01 by Univariate t-Test
NOTE: Multivariate Difference using all these variables P<.001
Lower Scores on Medical Attitudes = more favorable to comprehensive care
Higher Scores on Dogmatism = more dogmatic
Higher Scores on Semantic Differential = more positive

Subjective Evaluation: Although difficult to assess without controls, preceptor and student self-evaluations indicated that attitude and behavior changes occurred in students particularly in the area of learning to appreciate and relate to each others' disciplines. Major gains stated by students were: 1) becoming aware of the emotional correlates of physical illness; 2) understanding family interaction and its mutual effects; 3) learning that combined knowledge leads to better patient care; and 4) appreciating the importance of a social worker on the health team.

Other data which support success of the project are that nine of the 10 experimental medical students elected to care for their families another year, even though the team project had terminated. This fact combined

with a stated preference for family or general medicine as a career choice for six of the students is a further indication of project success. All the families elected to remain with the Family Health Center for continued care because of this positive experience.

CONCLUSIONS

It has been demonstrated that it is difficult to measure change in attitude; results might have been more significant if behavior rather than attitude were measured. Plans for the use of a behavior checklist with all groups did not materialize due to lack of funds and opportunities for continued observation of students' clinical behavior on other services. Future projects should include behavior measures such as observational rating scales, electives and career choices for all groups.

In some studies non-choosers have been used as controls. Our data would suggest that this is a risky procedure since there were differences between those who did or did not choose a Family Medicine elective. In this study, small sample size was a limiting factor. The finding of a P<13 difference between experimental and control groups with such a small sample could suggest differences might be found if a larger sample had been available.

The wide range of differences in attitudes of medical students and nurses although possibly attributable to age, sex, and educational levels, points to the need for more and better communication among health professionals. This limited project indicates that it would be valuable to have more opportunities for combined learning and working together for students from the different health disciplines. Studies of this type have further implications for curricular change in medical and other health professional schools.

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APPENDIX A

PRESENTATIONS AND PUBLICATIONS

A paper describing this project was accepted and presented at the 10th Annual Conference on Research in Medical Education, held in conjunction with the 82nd Annual Meeting of the Association of American Medical Colleges, November 1, 1971. The paper was published in the proceedings of that conference.

A similar condensed manuscript has been submitted to the Journal of Medical Education and accepted for future publication.

An article titled, "An Interprofessional Student Health Team Experience in a Family Clinic" was published by the nursing journal, Nursing Outlook, February, 1972, Volume 20, No. 2, 111-115.

Directions: This is a study of what medical students and people in the medical field think about a number of social and medical questions. The best answer to each statement below is your personal opinion. We have tried to cover many different points of view. You will find yourself strongly in favor of some and disagree strongly with others. For some statements your opinion will not be as clear cut. Whichever way you feel about any of the statements you can be certain that a good many people feel the way you do. Be sure to answer every item. After all, no knowledge, but only your opinion is involved. Think quickly; your immediate reaction to the statement is probably the best one. Read each statement carefully. Below it are five possible answers. Choose the answer you think best represents the way you feel and place a check mark in the space provided.

1. HOW IMPORTANT DO YOU THINK IT IS FOR THE DOCTOR TO KNOW THE EFFECT OF THE PATIENT'S ILLNESS ON HIS FAMILY IN ORDER TO PROVIDE ADEQUATE TREATMENT?

   ____ Not important at all
   ____ Pretty unimportant
   ____ Not so important
   ____ Pretty important
   ____ Very important

2. THE GREATEST SERVICE A PHYSICIAN CAN PROVIDE IS IN FOLLOWING LONG TERM HEALTH AND ADJUSTMENT OF PATIENTS AND FAMILIES RATHER THAN IN CONCENTRATING ONLY ON THE TREATMENT OF IMMEDIATE ILLNESS COMPLAINTS OF HIS PATIENTS.

   ____ Strongly disagree
   ____ Disagree
   ____ Undecided
   ____ Agree
   ____ Strongly agree

3. IN MEDICAL PRACTICE TODAY THERE ARE SUFFICIENT SPECIALISTS SO THAT A PHYSICIAN IN GENERAL PRACTICE SHOULD NOT ASSUME LONG TERM RESPONSIBILITY FOR HIS PATIENTS.

   ____ Completely disagree
   ____ Disagree
   ____ Undecided
   ____ Agree for the most part
   ____ Completely agree

4. THE MEDICAL SCHOOL SHOULD TRAIN STUDENTS FOR SPECIALTIES RATHER THAN GENERAL PRACTICE.

   ____ Disagree completely
   ____ Disagree
   ____ Undecided
   ____ Agree
   ____ Agree completely

5. DO YOU THINK THAT AS A PHYSICIAN YOU WOULD PREFER TO HAVE FOR YOUR PATIENTS ALL MEMBERS OF A FAMILY RATHER THAN PATIENTS AS INDIVIDUALS?

____ Definitely not
____ No
____ Undecided
____ Yes
____ Definitely yes

6. THE MOST IMPORTANT FUNCTION OF THE PHYSICIAN IS TO IMMEDIATELY RELIEVE THE SUFFERING OF THE PATIENT.

____ Strongly disagree
____ Disagree
____ Undecided
____ Agree
____ Strongly agree

7. IN A GENERAL PRACTICE THERE IS NO REASON TO STRESS GOOD HEALTH AND PROMOTE DISEASE PREVENTION SINCE THE AVERAGE PATIENT ONLY WANTS TO PAY FOR THE ALLEVIATION OF HIS DISEASE.

____ For practically no cases at all
____ For very few cases
____ For some cases
____ For most cases
____ For practically all cases

8. HOW PRACTICAL DO YOU THINK IT IS FOR A DOCTOR IN CLINICAL PRACTICE TO TAKE TIME TO FOLLOW UP PROVOCATIVE CLUES OTHER THAN THE PRESENTING SYMPTOMS?

____ It is always impractical
____ It is usually impractical
____ Undecided
____ It is usually practical
____ It is always practical

9. DO YOU THINK MEDICAL TRAINING IN THE CLINICAL YEARS SHOULD CONCENTRATE MOST OF THE STUDENT'S TIME ON EVALUATION AND TREATMENT OF SPECIFIC DISEASE PROCESSES?

____ Definitely not
____ No
____ Undecided
____ Yes
____ Definitely yes

10. A SPECIALIST SUCH AS AN OTOLOGIST, GYNECOLOGIST, PSYCHIATRIST, ETC., GENERALLY WOULD BE LESS EFFECTIVE ON A ROUTINE HOME CALL THAN A GENERAL PRACTITIONER.

____ Strongly disagree
____ Disagree
____ Undecided
____ Agree
____ Strongly agree

11. DO YOU THINK THAT IN A MEDICAL SETTING, THE DOCTOR SHOULD HAVE ALL PERSONNEL INVOLVED IN THE TREATMENT OF PATIENTS PARTICIPATE IN CASE DISCUSSIONS REGARDLESS OF THEIR PROFESSION?

____ Almost never
____ Not very often
____ Quite often
____ Usually
____ Almost always

12. TO WHAT EXTENT DO YOU THINK A MEDICAL DOCTOR IN A CLINICAL TEAM SHOULD CONSULT WITH THE TEAM MEMBERS, SUCH AS SOCIAL WORKER, PSYCHOLOGIST,. ETC., BEFORE MAKING BASIC DECISIONS IN THE MANAGEMENT OF THE PATIENT, SUCH AS DISCHARGE, REFERRALS, OR PRONOUNCED CHANGES IN THERAPY?

____ In none of his cases
____ In some of his cases
____ In about half of his cases
____ In most of his cases
____ In nearly all of his cases

13. HOW IMPORTANT DO YOU THINK IT IS TO HAVE NONMEDICAL SPECIALISTS INCLUDED ON A TREATMENT TEAM IN A MEDICAL SETTING?

____ Not important at all
____ Pretty unimportant
____ Not so important
____ Pretty important
____ Very important

14. THE MEDICAL DOCTOR IN A CLINICAL TEAM CONSISTING OF PSYCHOLOGIST, SOCIAL WORKER, NURSE, THERAPISTS, AND TECHNICIANS SHOULD TAKE A DECIDEDLY DIRECTIVE RATHER THAN COORDINATING POSITION IF TREATMENT IS TO BE EFFECTIVE.

____ Strongly disagree
____ Disagree
____ Undecided
____ Agree
____ Strongly agree

15. HOW IMPORTANT DO YOU THINK IT IS FOR A PHYSICIAN TO ACTIVELY PARTICIPATE IN ORGANIZED STATE PUBLIC HEALTH PROGRAMS?

____ Not important at all
____ Pretty unimportant
____ Not so important
____ Pretty important
____ Very important

16. A MEDICAL DOCTOR IS FREE TO DECIDE WHETHER OR NOT HE WANTS TO ACCEPT THE OPINION OF A CONSULTANT.

____ Almost never
____ Seldom
____ Undecided
____ Quite often
____ Almost always

17. IN GENERAL CLINICAL PRACTICE A MEDICAL SOCIAL WORKER IS UNNECESSARY PROVIDED AN EXPERIENCED NURSE IS AVAILABLE.

____ Disagree completely
____ Disagree
____ Undecided
____ Agree for the most part
____ Agree completely

18. A MEDICAL DOCTOR SHOULD ACCEPT THE OPINION OF A CONSULTANT WITHOUT RESERVATION.

____ Never
____ Seldom
____ Undecided
____ Most of the time
____ Always

19. AFTER A PHYSICIAN HAS EXPLAINED THE MEDICAL DIAGNOSIS AND PROGNOSIS OF A PATIENT TO HIS RELATIVES HE REFERS THE FAMILY TO THE SOCIAL WORKER FOR FURTHER DISCUSSION OF THEIR REACTIONS TO THE PATIENT'S DIAGNOSIS AND ILLNESS. HOW GOOD A PRACTICE DO YOU THINK THIS IS?

____ A very poor practice
____ A somewhat poor practice
____ Undecided
____ A fairly good practice
____ A very good practice

20. A PATIENT'S ABILITY TO PAY FOR MEDICAL SERVICES SHOULD NOT INFLUENCE TREATMENT GIVEN BY THE DOCTOR.

____ Strongly disagree
____ Disagree
____ Undecided
____ Agree
____ Strongly agree

21. ADEQUATE TREATMENT CANNOT BE DONE UNLESS PERSONAL RELATIONS WITH PATIENTS ARE KEPT TO A MINIMUM.

____ Disagree completely
____ Disagree
____ Undecided
____ Agree for the most part
____ Agree completely

22. A DOCTOR GENERALLY SHOULD REFUSE TO CARE FOR PATIENTS THAT DEFINITELY INDICATE UNFAVORABLE RESPONSE TO TREATMENT.

____ Completely disagree
____ Disagree
____ Undecided
____ Agree for the most part
____ Completely agree

23. HOW OFTEN DO YOU THINK THAT TO DO AN ADEQUATE JOB AS A DOCTOR, YOUR PERSONAL LIFE SHOULD BE SUBORDINATED TO THE DEMANDS OF CARING FOR PATIENTS?

____ Not very often
____ Quite often
____ About half the time
____ Almost always
____ Always

24. IN GENERAL PRACTICE A DOCTOR SHOULD REFUSE TO TREAT PATIENTS WITH DISEASE PROCESSES BECAUSE HE IS NOT INTERESTED IN THEM. TO WHAT EXTENT DO YOU AGREE?

____ Strongly disagree
____ Disagree
____ Undecide
____ Agree
____ Strongly agree

25. DO YOU THINK A DOCTOR SHOULD FEEL FREE TO REFUSE THE CARE OF PATIENTS WHO HE THINGS WILL BE UNCOOPERATIVE?

____ He almost never should refuse
____ He usually should not refuse
____ Undecided
____ He occasionally should refuse
____ He almost always should refuse

26. GENERALLY THE MORE ILLNESSES A DOCTOR SEES THE LESS CONCERNED HE WILL BE WITH THE SUFFERING OF PATIENTS.

____ Completely disagree
____ Disagree
____ Undecided
____ Agree for most part
____ Completely agree

27. HOW MUCH SHOULD A DOCTOR TRY TO FIND OUT ABOUT THE PERSONAL PROBLEMS OF HIS PATIENTS IN ADDITION TO PROBLEMS RELATED TO THEIR ILLNESSES?

____ Hardly anything at all
____ Very little
____ Not so much
____ Very much
____ As much as possible

28. HOW MUCH DO YOU THINK PATIENTS CAN CONTRIBUTE TO THE TREATMENT PROCESS DURING THEIR ILLNESS?

____ Practically nothing
____ Very little
____ Only a limited amount
____ Quite a lot
____ A very large amount

29. DO YOU THINK THAT IN A REGULAR OFFICE PRACTICE A BUSY DOCTOR CAN PROVIDE TIME TO TALK WITH EACH INDIVIDUAL PATIENT ABOUT PROBLEMS OTHER THAN HIS IMMEDIATE COMPLAINTS?

____ Almost never
____ Not very often
____ Undecided
____ Usually
____ Almost always

30. MOST PEOPLE WHO ARE INTERESTED IN PSYCHIATRY HAVE EMOTIONAL PROBLEMS OF THEIR OWN.

____ Disagree completely
____ Disagree somewhat
____ Undecided
____ Agree somewhat
____ Agree completely

31. THE GREAT MAJORITY OF SO-CALLED MENTAL DISORDERS CAN BE TRACED DIRECTLY TO AN HEREDITARY TENDENCY OF SOME SORT.

____ Disagree completely
____ Disagree somewhat
____ Undecided
____ Agree somewhat
____ Agree completely

32. PSYCHIATRIC TREATMENT IS A LUXURY RATHER THAN A REAL NECESSITY TO MOST PATIENTS WHO ASK FOR IT.

____ Disagree completely
____ Disagree somewhat
____ Undecided
____ Agree somewhat
____ Agree completely

33. AN EMOTIONAL UPSET SHOULD BE AS ACCEPTABLE AN EXCUSE FOR MISSING A FINAL EXAMINATION AS WOULD A SEVERE COLD.

____ Disagree completely
____ Disagree somewhat
____ Undecided
____ Agree somewhat
____ Agree completely

34. A SOUND PRACTITIONER RESERVES HIS TIME FOR REALLY ILL PERSONS RATHER THAN NEUROTIC ONES.

____ Disagree completely
____ Disagree somewhat
____ Undecided
____ Agree somewhat
____ Agree completely

35. THE EXCLUSIVE USE OF SIMPLE REASSURANCE AND PLACEBOS (e.g., sugar pills and other palliative techniques) IN THE TREATMENT OF NEUROTICS IS JUSTIFIED IN VIEW OF THE LACK OF EVIDENCE CONCERNING THE EFFECTIVENESS OF MORE COMPLICATED THERAPY.

____ Disagree completely
____ Disagree somewhat
____ Undecided
____ Agree somewhat
____ Agree completely

36. IT IS USEFUL FOR SOCIETY TO DIVIDE PEOPLE INTO CATEGORIES OF "SANE" OR "INSANE."

____ Disagree completely
____ Disagree somewhat
____ Undecided
____ Agree somewhat
____ Agree completely

37. PATIENTS ILL WITH EMOTIONAL DISORDERS NUMBER MORE THAN THE TOTAL OF CIVILIAN PATIENTS IN OUR HOSPITALS FOR ALL THE MEDICAL AND SURGICAL ILLNESSES PUT TOGETHER.

____ Disagree completely
____ Disagree somewhat
____ Undecided
____ Agree somewhat
____ Agree completely

38. BEHAVIOR PATTERNS CAN BE ALTERED AT MOST ANY LIFE PERIOD--IN CHILDHOOD, ADOLESCENCE, AND ADULTHOOD.

____ Disagree completely
____ Disagree somewhat
____ Undecided
____ Agree somewhat
____ Agree completely

39. PSYCHIATRIC KNOWLEDGE IS ESSENTIAL TO THE TREATMENT OF MORE THAN HALF OF THE PATIENTS A PHYSICIAN SEES IN HIS PRACTICE.

____ Disagree completely
____ Disagree somewhat
____ Undecided
____ Agree somewhat
____ Agree completely

40. INTELLECTUALLY GIFTED CHILDREN ARE LIKELY TO BE WEAK AND RETARDED PHYSICALLY AND EMOTIONALLY UNSTABLE.

____ Disagree completely
____ Disagree somewhat
____ Undecided
____ Agree somewhat
____ Agree completely

41. HEALTH SUPERVISION AS COMPARED WITH CURATIVE MEDICINE IS UNINTERESTING AND PROFITABLE TO THE PHYSICIAN.

___ Definitely not
___ No
___ Undecided
___ Yes
___ Definitely yes

42. HYGIENE, OFTEN DEFINED AS THE SCIENCE OF HEALTH, IS AS MUCH A SCIENCE AS INTERNAL MEDICINE AND PEDIATRICS.

___ Disagree completely
___ Disagree
___ Undecided
___ Agree
___ Agree completely

43. SPECIFIC KNOWLEDGE NECESSARY FOR PREVENTION OF DISEASE IS SO LIMITED AT THIS STAGE OF DEVELOPMENT THAT THE TIME OF A PRACTICING PHYSICIAN IS MUCH BETTER SPENT IN CURATIVE MEDICINE.

___ Completely disagree
___ Disagree
___ Undecided
___ Agree for the most part
___ Completely agree

44. FOR A WELL-ROUNDED MEDICAL EDUCATION, WORK IN PEDIATRICS AND SURGERY IS DECIDEDLY MORE IMPORTANT THAN WORK IN PREVENTIVE MEDICINE.

___ Strongly disagree
___ Disagree
___ Undecided
___ Agree
___ Strongly agree

45. PREVENTIVE MEDICINE NECESSITATES A DEGREE OF UNDERSTANDING OF PATIENT'S ATTITUDE TOWARD HEALTH AND DISEASE THAT IS UNUSUAL IN THE CURRENT PRACTICE OF MEDICINE.

___ Completely disagree
___ Disagree
___ Undecided
___ Agree for the most part
___ Completely agree

46. IN PRESENT DAY PRACTICE THE DEMAND FOR TREATMENT OF DISEASE IS SO GREAT THAT HARDLY ANY TIME CAN BE SPARED TO CONCERN ONESELF WITH PREVENTION OF ILLNESS.

___ Completely disagree
___ Disagree
___ Undecided
___ Agree for the most part
___ Completely agree

47. HOW IMPORTANT DO YOU THINK IT IS FOR A PHYSICIAN TO PARTICIPATE IN PROGRAMS OF ACCIDENT PREVENTION?

____ Not important at all
____ Pretty unimportant
____ Not so important
____ Pretty important
____ Very important

48. SINCE PREVENTION OF DISEASE IS DIRECTLY RELATED TO THE PROPERTIES OF DISEASE ITSELF, THERE IS NO SPECIAL REASON TO TEACH THE PREVENTIVE ASPECTS IN SEPARATE COURSES.

____ Disagree completely
____ Disagree
____ Undecided
____ Agree
____ Agree completely

49. THERE IS LITTLE VALUE IN STRESSING PRINCIPLES OF DISEASE PREVENTION AS PERSONAL HABITS OF MOST ADULT PATIENTS ARE SO FIRMLY ESTABLISHED THAT THE POSSIBILITY OF EFFECTING MORE LASTING CHANGE IS RATHER UNLIKELY.

____ Disagree completely
____ Disagree
____ Undecided
____ Agree
____ Agree completely

50. PREVENTION OF DISEASE AS A MEDICAL ACTIVITY IS PRIMARILY THE RESPONSIBILITY OF HEALTH DEPARTMENTS RATHER THAN THE RESPONSIBILITY OF BEDSIDE PHYSICIANS.

____ Disagree completely
____ Disagree
____ Undecided
____ Agree for the most part
____ Agree completely

Appendix C

ROKEACH E SCALE

The following is a study of what the general public thinks and feels about a number of important social and personal questions. The best answer to each statement below is your personal opinion. We have tried to cover many different and opposing points of view you may find yourself agreeing strongly with some of the statements, disagreeing just as strongly with others, and perhaps uncertain about others; whether you agree or disagree with any statement, you can be sure that many people feel the same as you do.

Mark each statement in the left margin according to how much you agree or disagree with it. Please mark every one. Write +1, +2, +3, or -1, -2, -3, depending on how you feel in each case.

+1: I agree a little
+2: I agree on the whole
+3: I agree very much

-1: I disagree a little
-2: I disagree on the whole
-3: I disagree very much

___ 1. The United States and Russia have just about nothing in common.

___ 2. The highest form of government is a democracy and the highest form of democracy is a government run by those who are most intelligent.

___ 3. Even though freedom of speech for all groups is a worthwhile goal, it is unfortunately necessary to restrict the freedom of certain political groups.

___ 4. It is only natural that a person would have a much better acquaintance with ideas he believes in than with ideas he opposes.

___ 5. Man on his own is a helpless and miserable creature.

___ 6. Fundamentally, the world we live in is a pretty lonesome place.

___ 7. Most people just don't give a "damn" for others.

___ 8. I'd like it if I could find someone who would tell me how to solve my personal problems.

___ 9. It is only natural for a person to be rather fearful of the future.

___ 10. There is so much to be done and so little time to do it in.

___ 11. Once I get wound up in a heated discussion I just can't stop.

___ 12. In a discussion I often find it necessary to repeat myself several times to make sure I am being understood.

___ 13. In a heated discussion I generally become so absorbed in what I am going to say that I forget to listen to what the others are saying.

___ 14. It is better to be a dead hero than to be a live coward.

___ 15. While I don't like to admit this even to myself, my secret ambition is to become a great man, like Einstein, or Beethoven or Shakespeare.

___ 16. The main thing in life is for a person to want to do something important.

___ 17. If given the chance I would do something of great benefit to the world.

___ 18. In the history of mankind there have probably been just a handful of really great thinkers.

___ 19. There are a number of people I have come to hate because of the things they stand for.

___ 20. A man who does not believe in some great cause has not really lived.

___ 21. It is only when a person devotes himself to an ideal or cause that life becomes meaningful.

___ 22. Of all the different philosophies which exist in this world there is probably only one which is correct.

___ 23. A person who gets enthusiatic about too many causes is likely to be a pretty "wishy-washy" sort of person.

___ 24. To compromise with our political opponents is dangerous because it usually leads to the betrayal of our own side.

___ 25. When it comes to differences of opinion in religion we must be careful not to compromise with those who believe differently from the way we do.

___ 26. In times like these, a person must be pretty selfish if he considers primarily his own happiness.

___ 27. The worst crime a person could commit is to attack publicly the people who believe in the same thing he does.

___ 28. In times like these it is often necessary to be more on guard against ideas put out by people or groups in one's own camp than by those in the opposing camp.

___ 29. A group which tolerates too much differences op opinion among its own members cannot exist for long.

___ 30. There are two kinds of people in this world: those who are for the truth and those who are against the truth.

___ 31. My blood boils whenever a person stubbornly refuses to admit he's wrong.

___ 32. A person who thinks primarily of his own happiness is beneath contempt.

___ 33. Most of the ideas which get printed nowadays aren't worth the pater they are printed on.

___ 34. In this complicated world of ours the only way we can know what's going on is to rely on leaders or experts who can be trusted.

___ 35. It is often desirable to reserve judgment about what's going on until one has had a chance to hear the opinions of those one respects.

___ 36. In the long run the best way to live is to pick friends and associates whose tastes and beliefs are the same as one's own.

___ 37. The present is all too often full of unhappiness. It is only the future that counts.

___ 38. If a man is to accomplish his mission in life it is sometimes necessary to gamble "all or nothing at all."

___ 39. Unfortunately, a good many people with whom I have discussed important social and moral problems don't really understand what's going on.

___ 40. Most people just don't know what's good for them.

Appendix D

HOSPITAL

1.	active	_____:_____:_____:_____:_____:_____:_____:	passive
2.	reputable	_____:_____:_____:_____:_____:_____:_____:	disreputable
3.	serious	_____:_____:_____:_____:_____:_____:_____:	humorous
4.	chaotic	_____:_____:_____:_____:_____:_____:_____:	ordered
5.	foolish	_____:_____:_____:_____:_____:_____:_____:	wise
6.	important	_____:_____:_____:_____:_____:_____:_____:	unimportant
7.	deep	_____:_____:_____:_____:_____:_____:_____:	shallow
8.	boring	_____:_____:_____:_____:_____:_____:_____:	interesting
9.	emotional	_____:_____:_____:_____:_____:_____:_____:	rational
10.	valuable	_____:_____:_____:_____:_____:_____:_____:	worthless
11.	weak	_____:_____:_____:_____:_____:_____:_____:	strong
12.	unsuccessful	_____:_____:_____:_____:_____:_____:_____:	successful
13.	regressive	_____:_____:_____:_____:_____:_____:_____:	progressive
14.	positive	_____:_____:_____:_____:_____:_____:_____:	negative
15.	harmonious	_____:_____:_____:_____:_____:_____:_____:	dissonant

DOCTOR

1.	active	_____:_____:_____:_____:_____:_____:_____:	passive
2.	reputable	_____:_____:_____:_____:_____:_____:_____:	disreputable
3.	serious	_____:_____:_____:_____:_____:_____:_____:	humorous
4.	chaotic	_____:_____:_____:_____:_____:_____:_____:	ordered
5.	foolish	_____:_____:_____:_____:_____:_____:_____:	wise
6.	important	_____:_____:_____:_____:_____:_____:_____:	unimportant
7.	deep	_____:_____:_____:_____:_____:_____:_____:	shallow
8.	boring	_____:_____:_____:_____:_____:_____:_____:	interesting
9.	emotional	_____:_____:_____:_____:_____:_____:_____:	rational
10.	valuable	_____:_____:_____:_____:_____:_____:_____:	worthless
11.	weak	_____:_____:_____:_____:_____:_____:_____:	strong
12.	unsuccessful	_____:_____:_____:_____:_____:_____:_____:	successful
13.	regressive	_____:_____:_____:_____:_____:_____:_____:	progressive
14.	positive	_____:_____:_____:_____:_____:_____:_____:	negative
15.	harmonious	_____:_____:_____:_____:_____:_____:_____:	dissonant

NURSE

1.	active	_____:_____:_____:_____:_____:_____:_____:	passive
2.	reputable	_____:_____:_____:_____:_____:_____:_____:	disreputable
3.	serious	_____:_____:_____:_____:_____:_____:_____:	humorous
4.	chaotic	_____:_____:_____:_____:_____:_____:_____:	ordered
5.	foolish	_____:_____:_____:_____:_____:_____:_____:	wise
6.	important	_____:_____:_____:_____:_____:_____:_____:	unimportant
7.	deep	_____:_____:_____:_____:_____:_____:_____:	shallow
8.	boring	_____:_____:_____:_____:_____:_____:_____:	interesting
9.	emotional	_____:_____:_____:_____:_____:_____:_____:	rational
10.	valuable	_____:_____:_____:_____:_____:_____:_____:	worthless
11.	weak	_____:_____:_____:_____:_____:_____:_____:	strong
12.	unsuccessful	_____:_____:_____:_____:_____:_____:_____:	successful
13.	regressive	_____:_____:_____:_____:_____:_____:_____:	progressive
14.	positive	_____:_____:_____:_____:_____:_____:_____:	negative
15.	harmonious	_____:_____:_____:_____:_____:_____:_____:	dissonant

PATIENT

1.	active	_____:_____:_____:_____:_____:_____:_____:	passive
2.	reputable	_____:_____:_____:_____:_____:_____:_____:	disreputable
3.	serious	_____:_____:_____:_____:_____:_____:_____:	humorous
4.	chaotic	_____:_____:_____:_____:_____:_____:_____:	ordered
5.	foolish	_____:_____:_____:_____:_____:_____:_____:	wise
6.	important	_____:_____:_____:_____:_____:_____:_____:	unimportant
7.	deep	_____:_____:_____:_____:_____:_____:_____:	shallow
8.	boring	_____:_____:_____:_____:_____:_____:_____:	interesting
9.	emotional	_____:_____:_____:_____:_____:_____:_____:	rational
10.	valuable	_____:_____:_____:_____:_____:_____:_____:	worthless
11.	weak	_____:_____:_____:_____:_____:_____:_____:	strong
12.	unsuccessful	_____:_____:_____:_____:_____:_____:_____:	successful
13.	regressive	_____:_____:_____:_____:_____:_____:_____:	progressive
14.	positive	_____:_____:_____:_____:_____:_____:_____:	negative
15.	harmonious	_____:_____:_____:_____:_____:_____:_____:	dissonant

SOCIAL WORKER

1.	active	_____	_____	_____	_____	_____	_____	passive
2.	reputable	_____	_____	_____	_____	_____	_____	disreputable
3.	serious	_____	_____	_____	_____	_____	_____	humorous
4.	chaotic	_____	_____	_____	_____	_____	_____	ordered
5.	foolish	_____	_____	_____	_____	_____	_____	wise
6.	important	_____	_____	_____	_____	_____	_____	unimportant
7.	deep	_____	_____	_____	_____	_____	_____	shallow
8.	boring	_____	_____	_____	_____	_____	_____	interesting
9.	emotional	_____	_____	_____	_____	_____	_____	rational
10.	valuable	_____	_____	_____	_____	_____	_____	worthless
11.	weak	_____	_____	_____	_____	_____	_____	strong
12.	unsuccessful	_____	_____	_____	_____	_____	_____	successful
13.	regressive	_____	_____	_____	_____	_____	_____	progressive
14.	positive	_____	_____	_____	_____	_____	_____	negative
15.	harmonious	_____	_____	_____	_____	_____	_____	dissonant

FAMILY MEDICINE

1.	active	_____:_____:_____:_____:_____:_____:_____:	passive
2.	reputable	_____:_____:_____:_____:_____:_____:_____:	disreputable
3.	serious	_____:_____:_____:_____:_____:_____:_____:	humorous
4.	chaotic	_____:_____:_____:_____:_____:_____:_____:	ordered
5.	foolish	_____:_____:_____:_____:_____:_____:_____:	wise
6.	important	_____:_____:_____:_____:_____:_____:_____:	unimportant
7.	deep	_____:_____:_____:_____:_____:_____:_____:	shallow
8.	boring	_____:_____:_____:_____:_____:_____:_____:	interesting
9.	emotional	_____:_____:_____:_____:_____:_____:_____:	rational
10.	valuable	_____:_____:_____:_____:_____:_____:_____:	worthless
11.	weak	_____:_____:_____:_____:_____:_____:_____:	strong
12.	unsuccessful	_____:_____:_____:_____:_____:_____:_____:	successful
13.	regressive	_____:_____:_____:_____:_____:_____:_____:	progressive
14.	positive	_____:_____:_____:_____:_____:_____:_____:	negative
15.	harmonious	_____:_____:_____:_____:_____:_____:_____:	dissonant

INDIGENT FAMILY

1.	active	_____:_____:_____:_____:_____:_____:_____:	passive
2.	reputable	_____:_____:_____:_____:_____:_____:_____:	disreputable
3.	serious	_____:_____:_____:_____:_____:_____:_____:	humorous
4.	chaotic	_____:_____:_____:_____:_____:_____:_____:	ordered
5.	foolish	_____:_____:_____:_____:_____:_____:_____:	wise
6.	important	_____:_____:_____:_____:_____:_____:_____:	unimportant
7.	deep	_____:_____:_____:_____:_____:_____:_____:	shallow
8.	boring	_____:_____:_____:_____:_____:_____:_____:	interesting
9.	emotional	_____:_____:_____:_____:_____:_____:_____:	rational
10.	valuable	_____:_____:_____:_____:_____:_____:_____:	worthless
11.	weak	_____:_____:_____:_____:_____:_____:_____:	strong
12.	unsuccessful	_____:_____:_____:_____:_____:_____:_____:	successful
13.	regressive	_____:_____:_____:_____:_____:_____:_____:	progressive
14.	positive	_____:_____:_____:_____:_____:_____:_____:	negative
15.	harmonious	_____:_____:_____:_____:_____:_____:_____:	dissonant

PSYCHOSOMATIC MEDICINE

1.	active	_____:_____:_____:_____:_____:_____:_____:	passive
2.	reputable	_____:_____:_____:_____:_____:_____:_____:	disreputable
3.	serious	_____:_____:_____:_____:_____:_____:_____:	humorous
4.	chaotic	_____:_____:_____:_____:_____:_____:_____:	ordered
5.	foolish	_____:_____:_____:_____:_____:_____:_____:	wise
6.	important	_____:_____:_____:_____:_____:_____:_____:	unimportant
7.	deep	_____:_____:_____:_____:_____:_____:_____:	shallow
8.	boring	_____:_____:_____:_____:_____:_____:_____:	interesting
9.	emotional	_____:_____:_____:_____:_____:_____:_____:	rational
10.	valuable	_____:_____:_____:_____:_____:_____:_____:	worthless
11.	weak	_____:_____:_____:_____:_____:_____:_____:	strong
12.	unsuccessful	_____:_____:_____:_____:_____:_____:_____:	successful
13.	regressive	_____:_____:_____:_____:_____:_____:_____:	progressive
14.	positive	_____:_____:_____:_____:_____:_____:_____:	negative
15.	harmonious	_____:_____:_____:_____:_____:_____:_____:	dissonant

INTERDISCIPLINARY HEALTH TEAM

1.	active	_____	_____	_____	_____	_____	_____	passive
2.	reputable	_____	_____	_____	_____	_____	_____	disreputable
3.	serious	_____	_____	_____	_____	_____	_____	humorous
4.	chaotic	_____	_____	_____	_____	_____	_____	ordered
5.	foolish	_____	_____	_____	_____	_____	_____	wise
6.	important	_____	_____	_____	_____	_____	_____	unimportant
7.	deep	_____	_____	_____	_____	_____	_____	shallow
8.	boring	_____	_____	_____	_____	_____	_____	interesting
9.	emotional	_____	_____	_____	_____	_____	_____	rational
10.	valuable	_____	_____	_____	_____	_____	_____	worthless
11.	weak	_____	_____	_____	_____	_____	_____	strong
12.	unsuccessful	_____	_____	_____	_____	_____	_____	successful
13.	regressive	_____	_____	_____	_____	_____	_____	progressive
14.	positive	_____	_____	_____	_____	_____	_____	negative
15.	harmonious	_____	_____	_____	_____	_____	_____	dissonant

SOCIALIZED MEDICINE

1.	active	_____:_____:_____:_____:_____:_____:_____:	passive
2.	reputable	_____:_____:_____:_____:_____:_____:_____:	disreputable
3.	serious	_____:_____:_____:_____:_____:_____:_____:	humorous
4.	chaotic	_____:_____:_____:_____:_____:_____:_____:	ordered
5.	foolish	_____:_____:_____:_____:_____:_____:_____:	wise
6.	important	_____:_____:_____:_____:_____:_____:_____:	unimportant
7.	deep	_____:_____:_____:_____:_____:_____:_____:	shallow
8.	boring	_____:_____:_____:_____:_____:_____:_____:	interesting
9.	emotional	_____:_____:_____:_____:_____:_____:_____:	rational
10.	valuable	_____:_____:_____:_____:_____:_____:_____:	worthless
11.	weak	_____:_____:_____:_____:_____:_____:_____:	strong
12.	unsuccessful	_____:_____:_____:_____:_____:_____:_____:	successful
13.	regressive	_____:_____:_____:_____:_____:_____:_____:	progressive
14.	positive	_____:_____:_____:_____:_____:_____:_____:	negative
15.	harmonious	_____:_____:_____:_____:_____:_____:_____:	dissonant

Appendix E

PRECEPTOR EVALUATION

Resident's Name_____ Date_____

Preceptor's Name_____

DIRECTIONS: Please circle the point on the scale under each question that best describes the resident's behavior at this time. Some sample behaviors are listed beside the first and last point on the scale. As you will note, 1 = the most positive response and 5 = the least positive response. If you think the resident only partially demonstrates some of these behaviors, select some point on the scale continuum between 1 and 5.

SECTIONS 1 - DOCTOR-PATIENT RELATIONSHIP

OVERALL ATTITUDE TOWARD PATIENTS

Shows interest in patient as a person, is warm, friendly, but professional in attitude, non-judgmental toward other cultures and styles of living.

Does not seem interested in patients, except as they represent disease, is not friendly, warm, or understanding, appears judgmental and biased with patients.

1 2 3 4 5

STUDENT'S ABILITY TO COMMUNICATE WITH PATIENTS

Uses clear appropriate questions and responses, uses language patients can understand, picks up on verbal and non-verbal cues, is able to establish positive relationships through use of effective interviewing skills.

Cannot relate to patients effectively, misses non-verbal cues, does not use appropriate language that patient understands.

1 2 3 4 5

CONTINUITY OF CARE

Is sensitive and responsible to total patient needs, recognizes importance of seeing patients regularly for health maintenance, providing for follow-up, planning for future health care based on previous patient contacts and knowledge of family.

Seems to understand only the immediate situation and relates care to that rather than a continuum of need.

1 2 3 4 5

COMPREHENSIVENESS OF CARE

Is complete in taking a history and physical, considers health education and preventive care, social and emotional aspects of health and illness, patient needs as well as demands, and can discuss these concepts with team as well as patients.

Is disease oriented, focuses on medical problems alone.

1 2 3 4 5

FAMILY ORIENTATION

Understands how family interaction, motivations, and roles affect health and illness of all family members, sees family as the unit of care.

Does not seem to see value in family orientation, focuses only on the patient and his problems.

1 2 3 4 5

STUDENT'S ATTITUDE TOWARD TEAM MEMBERS

Is able to work effectively with other team members, is friendly, cooperative, responsible, dependable, has positive attitude toward team approach.

Appears to have a negative attitude toward working with other members of the team.

1 2 3 4 5

COMMUNICATION WITH OTHER TEAM MEMBERS

Is able to relate to team members professionally, communicates ideas effectively, keeps team informed concerning his knowledge about the patient and family, and consults with other team members concerning their knowledge and perceptions.

Does not communicate with team members, is unable to relate or relates on a personal but not professional level, does not use information from other team members.

1 2 3 4 5

Preceptor Evaluation (continued)

UNDERSTANDING OF TEAM FUNCTION

Knows how various team members function, appropriately consults with team, exhibits behavior congruent with a comprehensive physician role.

Shows little or no understanding of roles of team members, does not use team approach.

1 2 3 4 5

FLEXIBILITY IN TEAM FUNCTION

Is secure enough in his role as a team member to recognize which member of the team should be more involved at which point in time and able to share medical treatment with others whose services may be called for, recognizes this kind of approach as practical and useful in delivery of health care.

Must always be the "leader" of the team, is unable to share or delegate responsibility for patient care, does not seem to appreciate the value in team approach.

1 2 3 4 5

FAMILY EVALUATION

1. The most important things our student health team accomplished were _____
_____
2. My major problems are _____
3. My family's major problems are _____
_____
4. My own state of health is _____
5. My spouse's state of health is _____
6. This experience with health care _____
7. During this experience my impression of nurses _____
8. During this experience my impression of social workers _____
9. During this experience my impression of doctors _____
10. Educational preparation of health professionals nowadays is _____
11. I think the reasons for this are _____
12. Comprehensive health care should _____
_____
13. This student health team project was really _____
_____
14. At the end of this experience our family _____
15. The positive aspects of this program for my family were _____
16. The negative aspects of this program for my family were _____
17. Some suggestions I have for the student health team project are _____
_____
18. If I was in charge of this program I would _____

Appendix G

Student Evaluation Questionnaire

1. The most important thing my team accomplished was_____
2. I never realized before that nurses_____
3. I never realized before that doctors_____
4. I never realized before that social workers_____
5. Implementation of the goals for our family's care was_____
6. Comprehensive family health care should_____
7. A team coordinator should be_____
8. Our greatest success with our family was in the area of_____
9. The faculty member who contributed the most was from the field of_____
10. At the end of this experience our family_____
11. This student health team experience was really_____
12. Members of my profession_____can make an important contribution to family care in the area of_____
13. Faculty participation was most meaningful when_____
14. In the future I think the interdisciplinary health team concept will_____
_____
15. Educational preparation of nurses nowadays is_____
16. I think the reason for this is_____
17. After this experience I see myself in relation to my profession as_____
18. Educational preparation of social workers nowadays is_____
19. I think the reason for this is_____
20. I think that educationally speaking this experience was_____
21. I see myself in relation to patients as_____
22. Educational preparation of physicians nowadays is_____
23. I think the reason for this is_____
24. Common educational experiences of physicians, social workers and nurses should include_____
25. If I was in charge of this clinic I would_____

APPENDIX H

FAMILY EVALUATION

1. The most important things our student health team accomplished were _____
_____
2. My major problems are _____
3. My family's major problems are _____
_____
4. My own state of health is _____
5. My spouse's state of health is _____
6. This experience with health care _____
7. During this experience my impression of nurses _____
8. During this experience my impression of social workers _____
9. During this experience my impression of doctors _____
10. Educational preparation of health professionals nowadays is _____
11. I think the reasons for this are _____
12. Comprehensive health care should _____
_____
13. This student health team project was really _____
_____
14. At the end of this experience our family _____
15. The positive aspects of this program for my family were _____
16. The negative aspects of this program for my family were _____
17. Some suggestions I have for the student health team project are _____
_____
18. If I was in charge of this program I would _____

Appendix I

INTERPERSONAL BEHAVIOR CHECK-LIST

Directions: Place a check next to each item that describes a behavior of the student during a single incident of patient care. (This may be an in-patient, private, ward or ambulatory visit.) If the behavior cannot be evaluated, mark the item N/A. Use a 0 if behavior was not accomplished but was applicable.

√=Positive
0=Negative
NA=Not Applicable

1. :_____: Reads chart before seeing patient
2. :_____: Individualizes the patient (calls him by name, looks in his face, etc.)
3. :_____: Introduces himself
4. :_____: Explains purpose of his presence
5. :_____: Introduces patient to other health team members present
6. :_____: Is pleasant (smiles, shakes hands, etc.)
7. :_____: Allows ample time to hear patient's complaints
8. :_____: Appears alert and attentive (uses verbal and non-verbal responses)
9. :_____: Is calm (does not exhibit tremulousness, hyperactivity, pressure for speech, etc.)
10. :_____: Uses words that patient can understand
11. :_____: Answers patients questions fully
12. :_____: Inquires about patients understanding of instructions
13. :_____: Does not impose personal beliefs upon actions of patient
14. :_____: Is responsive to non-verbal cues, such as demonstrations of pain or discomfort (interprets to patient or discusses with observer.)
15. :_____: Asks questions concerning social and emotional history
16. :_____: Explores patient's (feeling and concerns, fear, stresses, family problem.)
17. :_____: Gives explanation of procedures
18. :_____: Keeps patient draped to avoid embarrassment
19. :_____: Attends to patient's comfort (by being physically gentle)
20. :_____: Seeks to determine health needs of the family as well as the patient and plans intervention
21. :_____: Explains and utilizes community resources (medical, surgical, psychiatric consultation, legal aid, social or medical services, voluntary agencies, etc.)
22. :_____: Encourages patient and family to participate in planning and giving care (gives adequate instructions, encourages preventative care, uses demonstration and educational aids)
23. :_____: Explains any delay or need to leave patient waiting
24. :_____: Terminates session by using patient's name, walking to the door with patient, etc.

Appendix J

FAMILY HEALTH CARE PLAN

PRESENT PROBLEM AREAS	TREATMENT LONG TERM GOALS SHORT TERM GOALS	PROCESS OR MODES OR INTERVENTION APPROACHES	EVALUATION AND/OR RESULTS